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COMMISSION TO REVIEW OVERCROWDING AT THE AUGUSTA MENTAL HEALTH INSTITUTE AND THE BANGOR MENTAL HEALTH INSTITUTE

FINAL REPORT

October 1988

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CONTENTS

Summary and Recommendations ii

I. Introduction 1

II. General Assessment and Long Term Plan 4

III. Community Based Mental Health Services 7

IV. Inpatient services in local hospitals and
nursing homes 16

V. Overcrowding and Staffing Issues at AMHI and BMHI 26

VI. Conclusion 28

Appendix - Proposed Legislation.............................. 29

EXECUTIVE SUMMARY

The Maine Commission to Review Overcrowding at the Augusta Mental Health Institute and the Bangor Mental Health Institute was established by the first session of the 113th Legislature (Resolve 1987, c. 56). The impetus for its formation was the sharp increase in the patient census at the two State mental health institutes which was seen as posing "a hazard to the health and safety of both patients and staff."

The first report of the Commission was presented in December 1987 to the Second Regular Session of the 113th Legislature. It detailed "conditions and practices at the two mental health institutes."

This is the second report and it examines the need for and availability of community mental health and support services. It also assesses the adequacy of the Department of Mental Health and Mental Retardation's (DMH & MR) planning efforts with regard to establishing a long term solution to the needs of mentally ill individuals in Maine.

The overall charge of the Commission carried out in the two reports was to examine "overcrowding at the Augusta Mental Health Institute and the Bangor Mental Health Institute, including: the adequacy of programming and treatment alternatives for residents; the adequacy of current facilities, including space and environmental requirements, staffing patterns and patient-staff ratios; the impact of overcrowding on institution staff; safety of patients and community; community treatment and support services vital to the ongoing care of the mentally ill; the existing availability and scope of these community services; the relationship between the adequacy of these services and the existing conditions at the Augusta Mental Health Institute and the Bangor Mental Health Institute."

LIST OF RECOMMENDATIONS

RECOMMENDATION 1: The Department of Mental Health and Mental Retardation should, in its next biennial budget, include a request for funds to conduct a systems study (e.g., the Maine-Vermont Study) of the population to be served, including the needs of individuals in that population and the personnel and facilities required to serve those needs. The study should make use of the individual functional assessment system being developed by the Department. This study should form the basis for a client driven budget which should be used as a basis for the Department's biennial budget requests starting with the FY 1992-93 budget.

RECOMMENDATION 2: The Department of Mental Health and Mental Retardation shall, in consultation with the Maine Commission on Mental Health, mental health professionals, consumers, and family members draft a model statute governing the delivery of

mental health services for distribution to the Legislature in January 1990.

RECOMMENDATION 3: The Joint Standing Committee on Appropriations and Financial Affairs should work with the Department of Mental Health and Mental Retardation to develop a formula funding mechanism for a base budget using a unit cost of services identified by the patient funcitonal assessment system.

RECOMMENDATION 4: As part of the desired system, each client who is identified either as a state hospital patient or a community member in need of help must be offered a complete medical and psychiatric assessment. This includes the evaluation and correction of medical problems, and the evaluation and treatment of psychiatric problems. The psychiatric evaluation should include assessment as to whether this particular client/patient is an alcohol or substance abuser. Community hospital beds should be available for those people with acute exacerbations of their chronic mental illness. After discharge they can then return to their homes or be placed in the housing alternative most appropriate for them. (See housing) For those who have substance or alcohol abuse problems there should be detoxification units, rehabilitation programs and halfway house residences available to them within their community.

RECOMMENDATION 5: The Department of Mental Health and Mental Retardation should develop a range of residential options, from psychiatric boarding homes to independent apartments, which adequately meet the housing and residential support needs of persons with mental illness in all regions of the state. The goal should be to support a system of permanent homes for persons with mental illness in their own community. Staffing for support and skill training services should be provided in these "permanent homes." The level of staffing available should be flexible to meet the particular needs of individual clients at a given moment in time. The homes are not necessarily meant to be the only home available to an individual. The homes should be dispersed in the community.

RECOMMENDATION 6: Work training and career counselling should be part of and coordinated with other community support programs. The programs should develop work opportunities in real work settings. The staffing should include vocational rehabilitation specialists. The programs should provide job training and mental health support to the client and also needed support for employers and fellow employees to provide them with an understanding of the individual worker and to assure them reliable work coverage. Services should clearly take into consideration the desires as well as the potentials of clients. Clients should be given an opportunity to continue their education.

RECOMMENDATION 7: Skill training in activities of daily living should be an integrated part of a broad range of community support services. This skill training should pay attention to

the daily living skills needed on the job, in the home, in the community and in social interactions. This training should take place in a setting most advantageous to the client, including the client's home, workplace and community.

RECOMMENDATION 8: Community programs which offer social and recreational opportunities for individuals with mental illness during the day, evenings and weekends need to be part of the broad range of community support services. These need to provide a place where individuals can relax, socialize and develop leisure time interests. Where possible, clients should be helped to utilize the activities available to the general public in their community. In larger communities, these types of programs may also entail the operation of a special place or club. The State should not provide funding for programs which discriminate against mentally ill clients. Mentally ill individuals who also have a problem with substance abuse need access to AA and their families need access to Al-Anon.

RECOMMENDATION 9: In the establishment and coordination of services, the availability of transportation to services must be considered an integral part of the total package. Community service proposals which do not have a plan for assuring the transportation of clients to the program should be given a lower priority than those which do. The Department of Mental Health and Mental Retardation should encourage and assist in funding the development of models where volunteers can be reimbursed for expenses and be provided a minimum contribution for their services. The Department should establish inter-departmental cooperative agreements for the development of regional transportation systems. Employees who are involved in the transportation of clients should be reimbursed.

RECOMMENDATION 10: To be effectively delivered, the various components of community support services must be coordinated at the client's level. This client level coordination must set priorities for the expenditure of resources and must also insure needed services are developed. The Department of Mental Health and Mental Retardation in consultation with the Maine Commission on Mental Health, mental health professionals, consumers, and family members shall make recommendations to the Legislature on a mechanism for coordinating services by January 1990.

Recommendation 11: Case management services should be part of the package of client support services available in all areas of the state. A case manager should be responsible for insuring that mentally ill individuals receive the services they need and that their rights are protected. The Department of Mental Health and Mental Retardation in consultation with the Maine Commission on Mental Health, mental health professionals, consumers and family members shall develop a model of case management services by January 1990.

RECOMMENDATION 12: Crisis stabilization services should be a part of the total package of services available to chronically

mentally ill individuals in all areas of the state and shall work in concert with case management services. Upon release from the hospital, there should be a continuity of medical and psycho-therapeutic services to insure every opportunity for the individual to remain in the community.

RECOMMENDATION 13: The Department of Mental Health and Mental Retardation should work with the Attorney General's Office to expedite the development of procedures for the treatment of involuntary patients in local hospital psychiatric inpatient units. This should include a mechanism for timely transfers to one of the two State mental health institutes and for the protection of individual patient's rights.

RECOMMENDATION 14; The Department of Mental Health and Mental Retardation, the Department of Human Services, and the Maine Health Care Finance Commission (MHCFC) should set up a working group to develop appropriate regulations or proposed statutory changes so that State funding and approval mechanisms require hospital inpatient units and community service providers to communicate and cooperate on the treatment and transfer of patients between inpatient and community service programs.

RECOMMENDATION 15: The Department of Mental Health and Mental Retardation should conduct a statewide assessment of the need for psychiatric inpatient units in local community hospitals. This assessment should be incorporated in the system's study. Based on this assessment they should develop a plan for the location of community hospital inpatient units across the state. They should work with the certificate of need process in the Department of Human Services to provide the information which would expedite the applications of hospitals which meet the goals of the statewide plan.

RECOMMENDATION 16: The Department of Mental Health and Mental Retardation should actively bring community mental health providers and providers of hospital services in an area together and have them discuss how inpatient services should be developed in their area. The aim should be to provide necessary in-patient services based on client need within the local community. The Department should assist in the development of inpatient psychiatric units in those geographic areas where the department's assessment has determined that there is a need for a unit. The Department should report annually to the Maine Commission on Mental Health on its progress in implementing a plan for in-patient services. It is the intent of the Commission that all psychiatric beds in Maine shall adhere to patient rights and advocacy rules.

RECOMMENDATION 17: The Department of Mental Health and Mental Retardation should assess the need and availability of mental health professionals and workers in all regions of the state. They should develop a plan with the Department of Education, the Vocational-Technical Institute System, the University of Maine System, and other private, post secondary educational institutions to provide the preservice and continuing education

programs necessary to provide the personnel resources to meet the need in all regions of the state.

RECOMMENDATION 18: The Governor should inform both the President of the United States and the Maine Congressional delegation that it is imperative that the Federal government should participate to a greater extent in the funding of mental health services. Mental illnesses should be treated like other illnesses and disabilities. Federal programs like Medicare and Medicaid should pay for the care and treatment of the mental illnesses of otherwise eligible individuals. The Governor should direct the State Medicaid Agency to review mental health services in order to guarantee the maximization of Medicaid funds for needed client services.

RECOMMENDATION 19: The Department of Mental Health and Mental Retardation should develop a plan for delivering active treatment for persons with mental illness in nursing homes. Local mental health providers should be consulted in developing the plan.

RECOMMENDATION 20: The Department of Mental Health and Mental Retardation should work with the Veterans Hospital at Togus, community mental health providers, private institutions, and professional groups to develop a joint recruitment effort to attract needed mental health professionals to Maine.

I. INTRODUCTION

The Maine Commission to Review Overcrowding at the Augusta Mental Health Institute and the Bangor Mental Health Institute was established by the first session of the 113th Legislature (Resolve 1987, c. 56). The impetus for its formation was the sharp increase in the patient census at the two State mental health institutes which was seen as posing "a hazard to the health and safety of both patients and staff."

The charge of the Commission was to examine "overcrowding at the Augusta Mental Health Institute and the Bangor Mental Health Institute, including: the adequacy of programming and treatment alternatives for residents; the adequacy of current facilities, including space and environmental requirements, staffing patterns and patient-staff ratios; the impact of overcrowding on institution staff; safety of patients and community; community treatment and support services vital to the ongoing care of the mentally ill; the existing availability and scope of these community services; the relationship between the adequacy of these services and the existing conditions at the Augusta Mental Health Institute and the Bangor Mental Health Institute."

The Commission was to submit two reports to the Legislature. This first report, was presented in December 1987 to the Second Regular Session of the 113th Legislature. It detailed "conditions and practices at the two mental health institutes."

This is the second report and it examines the need for and availability of community mental health and support services. It also assesses the adequacy of the Department of Mental Health and Mental Retardation's (DMH & MR) planning efforts with regard to establishing a long term solution to the needs of mentally ill individuals in Maine.

SHORT HISTORY OF MENTAL HEALTH SERVICES IN MAINE

Prior to the 1960's, publicly funded health services in Maine were basically synonymous with the two State psychiatric hospitals -- the Augusta Mental Health Institute (AMHI) and the Bangor Mental Health Institute (BMHI). The major goal of the services was to protect society from the aberrant behavior of mentally ill individuals and to protect the mentally ill from their own self destructive acts. The services provided were largely custodial.

In 1958 the first community clinic was established in the Lewiston-Auburn area. Shortly after, other clinics began opening throughout the state, including some outpatient services run by AMHI and BMHI. In addition, in the late 1960's, psychiatric in-patient units began opening in a few of the state's general hospitals. With the passage of the federal

Community Mental Health Centers Act in 1963, federal funding was assured for the provision of several basic mental health services in the community and led to the expansion of the existing community services into a statewide network of community mental health centers. These efforts have continued despite federal block grant legislation enacted in 1981 which effectively negated the short-lived Mental Health Systems Act, reducing federal support and responsibility for high-risk population groups.

The reality of the change in locus of service efforts is documented by the decrease in the patient populations at both State institutes. While slow to start the population decreased at AMHI from 1553 to slightly under 300 at the start of the 1980s. The census at BMHI was over 1000 in the latter part of the 1960s and had decreased to under 300 by the 1980s.

CHANGING PHILOSOPHY OF SERVICE

While the protective function is still one of the paramount goals of mental health services, modern drug and other therapies have allowed additional goals to come more clearly into focus. Large custodial institutions were criticized as being dehumanizing. Many of the abnormal behaviors of patients were seen as a result of the institutional setting and not totally explained by the patients' mental illness. Patients were seen as having the right to receive services within the least restrictive setting and within their local communities. In addition, the treatment outlook became more optimistic. Services were perceived as being able to cure patients or at least help patients cope with their illness. Rehabilitative and job training skills have been increasingly emphasized. It has become recognized that support services for housing and activities of daily living should be available outside the confines of a total institutional setting.

CLIENT GROUP

The charge to the Commission was to review overcrowding at the two State mental health institutes. By definition, then, the Commission's focus was on the more seriously mentally ill individuals in the state. The Commission recognized that there are other individuals or groups with varying types of mental health problems who could benefit from State supported services. However, within the time frame of the Commission's work it was impossible to cover the total range of mental health problems in the state. This decision meant that, among other issues, the Commission had time to address neither the issue of preventive mental health services nor the provision of services for children with mental health problems. The following discussion and recommendations, therefore, are focused on services for severely mentally ill individuals and on solutions to the problem of overcrowding at the two State mental health institutes.

COMMISSION'S WORK PLAN

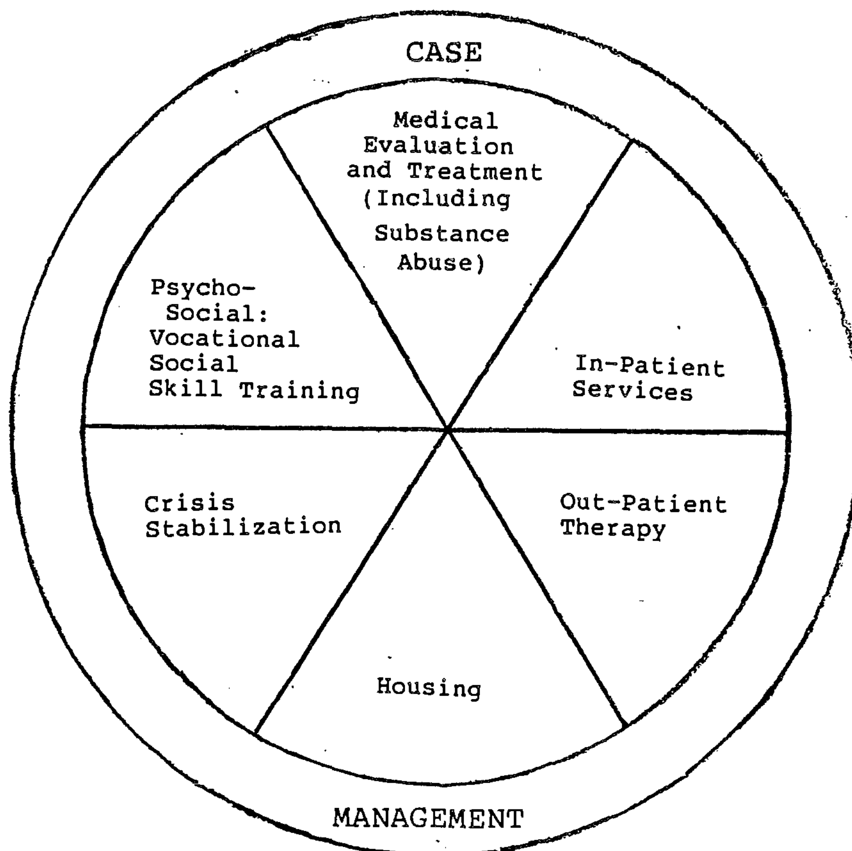
The focus of the Commission's work for the second report was on community services. To expedite their efforts they divided into two subgroups. One group examined the range of treatment and support services which were available or needed to be developed in the community. The other group focused on the issue of the provision of acute care inpatient services by local community hospitals and nursing homes. With regard to the two mental health institutes, the Commission also examined specific issues regarding the withdrawal of federal reimbursement for the care of certain patients at AMHI and the elimination of certain services at the Veterans Hospital at Togus. The work of the Commission in these three areas is discussed separately in the following material.

II. GENERAL ASSESSMENT AND LONG TERM PLAN

Through a special technical assistance grant, the National Conference of State Legislatures provided the consultant services of La Vonne Daniels to present a general overview of mental health system reforms across the country and to help the Commission reach decisions on its final recommendations. As the Commission was completing its work, Daniels was able to help bring some of the larger issues into focus and to provide a framework for the Commission to articulate two general recommendations. These were in addition to the specific recommendations the Commission discussed at earlier meetings. Included here is a brief description of her conceptualization of services and the general recommendations that the Commission developed out of the discussion.

Daniels listed out the components of the needed system of services. The Commission ordered these into a pie. (see diagram below). The six slices of the pie were: psycho-social services which include vocational training, social opportunities, and general daily activity skill development; medical management, including both in-patient and out-patient; crisis stabilization; housing; inpatient services; and finally out-patient therapy. Providing the surrounding crust, ringing and holding the pie together, is case management.

Diagram 1:



It became clear from Daniel's presentation and the Commission discussion that the development of an integrated and comprehensive system of services requires a clear definition of the population to be served and a clear delineation of the public responsibility in providing services. Daniel's felt that the Department of Mental Health and Mental Retardation's Community Forums and the Mental Health Advisory Council's Task Forces (which included local systems assessment and planning teams) provided an important foundation to understand the mental health needs of the State. However, she felt the next step was to conduct a basic systems study identifying individuals with mental illness and available services. Without a basic study defining the population in need of service, determining who they are and where they are located, assessing their level of need, and deciding the level of staff and facilities available to provide service, it is difficult to make concrete recommendations on the specific service elements which need to be provided and developed. To have lasting impact, such a study should also be followed by the establishment of a budgetary process and a case tracking system that will provide the necessary systems information in the future.

RECOMMENDATION 1: The Department of Mental Health and Mental Retardation should, in its next biennial budget, include a request for funds to conduct a systems study (e.g., the Maine-Vermont Study) of the population to be served, including the needs of individuals in that population and the personnel and facilities required to serve those needs. The study should make use of the individual functional assessment system being developed by the Department. This study should form the basis for a client driven budget which should be used as a basis for the Department's biennial budget requests starting with the FY 1992-93 budget.

A corollary to the need for a systematic study is the need to rewrite the statutes defining the role of the State in providing services or in monitoring their provision by independent agencies. The statutes should clearly define the mission and philosophy for mental health services in Maine. It should specify the priority by which individuals with mental illness will receive State support for services. It should enunciate rights of individuals with mental illness and provide standards for services and professional conduct for those funded or licensed by the State.

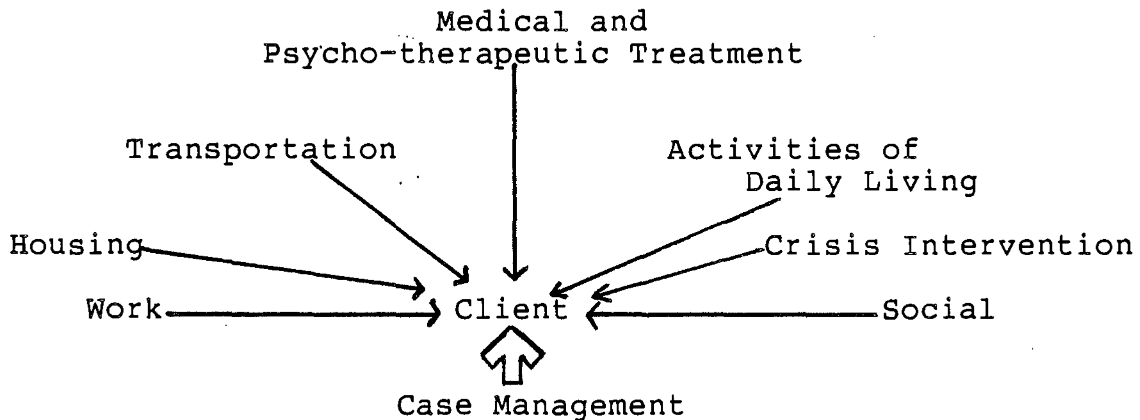
RECOMMENDATION 2: The Department of Mental Health and Mental Retardation shall, in consultation with the Maine Commission on Mental Health, mental health professionals, consumers, and family members draft a model statute governing the delivery of mental health services for distribution to the Legislature in January 1990.

RECOMMENDATION 3: The Joint Standing Committee on Appropriations and Financial Affairs should work with the Department of Mental Health and Mental Retardation to develop a formula funding mechanism for a base budget using a unit cost of services identified by the patient funcitonal assessment system.

III. COMMUNITY BASED MENTAL HEALTH SERVICES

Through a combination of hearing testimony from community providers, information collected from conducting site visits, presentations by DMH&MR staff on their department's regional forums and planning process, and written material presented from each region, the Commission and community subcommittee received input from providers in all of the mental health regions. In general, the members were impressed with the quality and the dedication of staff but found the range of services limited. In addition to supporting the traditional provision of therapeutic services, the members recognized that the successful placement or retention of mentally ill individuals, especially those with severe and chronic illnesses, in the community depends upon the integration of a variety of services. These local service needs were outlined in some detail in the summary the Department of Mental Health and Mental Retardation gave of the testimony at their regional forums. The regional forums highlighted, among others, the need for several categories of services. As indicated in the diagram below these include housing or residential services; job training; work activity programs and career development; help or training in activities of daily living; transportation; social and recreational activities; crisis intervention services and case management services.

Diagram 2.



<u>Medical and Psychiatric Evaluation and Treatment</u>

Each client after being identified should be offered a medical and psychiatric evaluation. If the client/patient is being discharged from AMHI, BMHI, or a community hospital, the evaluation should have already been completed. This person then requires continuity of psychiatric care, including psychotherapy and medication within the community. With a newly identified client/patient in the community, medical and psychiatric evaluation and need for treatment should be part of the overall assessment as shown in Diagram 2.

The evaluation should include diagnosis, and should be followed, if necessary, by the initiation of treatment with psychotherapy and psychotrophics. This evaluation should include not only examination for medical problems and mental illness but also evaluation for alcohol and substance abuse or the possibility of dual diagnosis.

If hospitalization is needed, beds for treatment should be available within the community. These would include psychiatric beds at local general hospitals, detoxification units, and alcohol and substance abuse rehabilitation inpatient beds and/or outpatient programs. Most chronically mentally ill patients (over 60%) have acute exacerbations of their illnesses resulting from increased stresses in their daily living or need for medication adjustment. These exacerbations can usually be handled within the community by hospitalization for 5-14 days. Many patients will accept voluntary admission within their own community rather than involuntary commitment to either AMHI or BMHI. A program for regular routine medical and psychiatric reevaluations should be part of each client/patient's long term care.

RECOMMENDATION 4: As part of the desired system, each client who is identified either as a state hospital patient or a community member in need of help must be offered a complete medical and psychiatric assessment. This includes the evaluation and correction of medical problems, and the evaluation and treatment of psychiatric problems. The psychiatric evaluation should include assessment as to whether this particular client/patient is an alcohol or substance abuser. Community hospital beds should be available for those people with acute exacerbations of their chronic mental illness. After discharge they can then return to their homes or be placed in the housing alternative most appropriate for them. (See housing) For those who have substance or alcohol abuse problems there should be detoxification units, rehabilitation programs and halfway house residences available to them within their community.

Housing

Housing was universally recognized as a major problem facing individuals who have a history of placements at the mental health institutes. From the testimony provided and from Commission site visits, the members learned that the type of housing required varied with the client's needs and the type of places available depended on the initiatives of particular individuals or organizations to meet the needs of particular groups of clients.

Transitional housing arrangements provide temporary housing immediately after discharge from AMHI or BMHI. Psychiatric boarding homes provide longer term options for individuals who, while capable of remaining in the community, need to have continual support services available. From there, there is a range of general boarding home and independent apartment living

arrangements with varying amounts of oversight or contact with support staff. Halfway houses for substance abusers meet the special needs of individuals with a dual diagnosis.

At present many of these types of living arrangements are available and sustainable only if there is a particular individual or group which is focused on maintaining the program. It is often problematic for small agencies to provide 24 hour or emergency coverage or coverage for vacations and sick days. Volunteers are an important part of the support services, but take considerable effort of paid staff or other volunteers to maintain and administer. The funding base for services requires juggling multiple sources of income and is typically not large or secure enough to enable the agencies to pay competitive salaries necessary to attract and retain staff easily.

Even at best, however, the present availability of housing services has the following problems:

1. Lack of a full range of options in every region of the state.
2. Lack of sufficient number of places to meet the entire need in every region.
3. Lack of administrative systems which allow depth in staffing to cover emergencies, vacations and sick days.
4. Lack of sufficient funding to insure adequate staff salaries.

In her presentation, La Vonne Daniels listed several basic principles around which housing services should be organized. Residential options for mentally ill individuals should be based on the principle of normalized housing. Mentally ill individuals should not generally be segregated into housing options which differ from those typically used by other members of the community. Following the first principle, she also felt that the housing should be designed for small numbers of clients and dispersed, as opposed to clustered, in the community. The commission members accepted the rationale for normalized and small unit housing. However, concerning the question of dispersed or clustered locations, they felt that it would be tempered partially by the availability of transportation to other services.

In regard to staff support, Daniels presented the idea of permanent residences for clients and flexible staffing arrangements. This is in contrast to the more typical model where staffing patterns are associated with particular settings -- heavily staffed psychiatric boarding homes to more independent or self-reliant apartments. Her point was that the needs of clients may change dramatically from one time period to another, and it only adds to the clients' confusion and retards their stabilization and rehabilitation to be moved from one residential setting to another as their need for support services change.

Federal 5013C Bonds are available through the Maine State Housing Authority for the development of housing for individuals with mental illness. These can be used to refinance existing property, finance the purchase of property or finance the building of new housing. The Housing Authority is presently working with the Department of Mental Health and Mental Retardation to expand the availability of housing alternatives.

RECOMMENDATION 5: The Department of Mental Health and Mental Retardation should develop a range of residential options, from psychiatric boarding homes to independent apartments, which adequately meet the housing and residential support needs of persons with mental illness in all regions of the state. The goal should be to support a system of permanent homes for persons with mental illness in their own community. Staffing for support and skill training services should be provided in these "permanent homes." The level of staffing available should be flexible to meet the particular needs of individual clients at a given moment in time. The homes are not necessarily meant to be the only home available to an individual. The homes should be dispersed in the community.

Work and Career Training and Placement

Work training and placement has become increasingly an important focal point for service. Work makes individuals productive citizens. It provides a major source of self esteem and public acceptance. This focus on jobs goes beyond the more traditional work activity and special work training programs. It includes innovative efforts to create jobs or real work situations. It also includes working with employers in the community. Some programs provide supervision and guarantee work coverage by assuring employers that an employee of the agency will show up for work if the person with mental illness is unable to come to work. Where those programs are tried and can find a job niche in the local economy, they appear to be very successful.

In addition to particular skill training, these programs must provide supports both to the individual client, employers, and fellow employees to deal with the psychological dimensions of the client's behavior. The work is used as a setting in which to help clients learn to cope with the problems related to their mental illness in real life environments. The support services need to help employers learn how to structure their work environment and to adjust the manner of dealing with employees to accommodate the mental health needs of employees with mental illness.

To garner the support necessary to make job training and placement successful, these programs must be seen as an integral part of a total package of community support services and need to be coordinated with these other services.

RECOMMENDATION 6: Work training should be part of and coordinated with other community support programs. The programs should develop work opportunities in real work settings. The staffing should include vocational rehabilitation specialists. The programs should provide job training and mental health support to the client and also needed support for employers and fellow employees to provide them with an understanding of the individual worker and to assure them reliable work coverage. Services should clearly take into consideration the desires as well as the potentials of clients. Clients should be given an opportunity to continue their education.

Activities of Daily Living

The successful functioning of people in the community often depends on their ability to carry out daily activities of living and to find informal support structures to help in situations where they are unable to cope on their own. Individuals with mental illness face the same problem. However, because of their illness, they may have fewer internal resources and an attenuated informal support structure.

A successful community program should include training programs and opportunities for individuals to develop daily living skills. These training or practice opportunities should be integrated with other housing, work experience or social activities and should not be seen as a distinct or isolated element. They should also be provided in the actual environment where the client will use them. This will entail staff working with clients in the client's home, neighborhood and community.

RECOMMENDATION 7: Skill training in activities of daily living should be an integrated part of a broad range of community support services. This skill training should pay attention to the daily living skills needed on the job, in the home, in the community and in social interactions. This training should take place in a setting most advantageous to the client, including the client's home, workplace and community.

Social and Recreational Activities

Social activities serve two functions. Former patients need a place where they can go and relax and know they are accepted. They also offer an opportunity for the development of social skills and leisure time interests. One of the skills of community living is to know how to occupy one's free time. Former patients often lack these skills or otherwise have difficulty appearing as though they are constructively engaged.

In addition to the benefits for the former patients, the community in general benefits. The former patients are not left to wander around the neighborhood or found staying longer than customarily welcome at certain shops, eating places or street corners. The community value of these programs was very apparent to some of the legislators on the Commission and they remarked on the decrease in problems raised by constituents when social clubs are available.

RECOMMENDATION 8: Community programs which offer social and recreational opportunities for individuals with mental illness during the day, evenings and weekends need to be part of the broad range of community support services. These need to provide a place where individuals can relax, socialize and develop leisure time interests. Where possible, clients should be helped to utilize the activities available to the general public in their community. In larger communities, these types of programs may also entail the operation of a special place or club. The State should not provide funding for programs which discriminate against mentally ill clients. Mentally ill individuals who also have a problem with substance abuse need access to AA and their families need access to Al-Anon.

Transportation

One of the elements of the structure brought out in the site visits to community agencies, and often mentioned in the Department of Mental Health and Mental Retardation forums, was the need for transportation services. Public transportation services are not available in most areas of the state and clients often cannot arrange for their own transportation to programs. In rural areas like Maine, the solutions are not easy. However, the responsibility for making services available should include consideration of transportation needs. If community support programs are an aid to reduce admissions to the institutes, then transportation is an important element in achieving that reduction. The commission felt that, where possible, transportation initiatives should utilize or be coordinated with local public transportation services or programs sponsored by the Department of Transportation.

RECOMMENDATION 9: In the establishment and coordination of services, the availability of transportation to services must be considered an integral part of the total package. Community service proposals which do not have a plan for assuring the transportation of clients to the program should be given a lower priority than those which do. The Department of Mental Health and Mental Retardation should encourage and assist in funding the development of models where volunteers can be reimbursed for expenses and be provided a minimum contribution for their services. The Department should establish inter-departmental cooperative agreements for the development of regional transportation systems. Employees who are involved in the transportation of clients should be reimbursed.

Coordination of Services

Integral to the above discussion of services is the understanding that they must be available. This does not just mean that there should be enough to meet the demand from all those who need them. It also means that the individuals who could use them know about them and that, in piecing together a package of services, individuals find that the range of services they need can be coordinated.

The typical pattern in an institutional setting is for the administration to provide and coordinate all services. At the independent agency level, agencies try to deal with the issue by establishing informal referral links, developing inter-agency coordination meetings, or alternatively trying to provide a wider range of services themselves.

At the Commission's request, DMH&MR presented some initial thoughts on how a coordinating function could be added to the existing mix of independent agencies and services. Some concern was raised as to whether these would be regional in nature or be organized on a community basis. The general consensus of the Commission was that coordination should be community based. The population and service base in Maine, however, will necessitate developing the coordination around larger entities than single municipalities.

Another coordination question is whether the function should be absorbed by existing agencies or whether there needs to be a new structure to develop coordination linkages. The answer seemed to vary from one region of the state to another. In certain areas, one agency is already dominant and provides most of the services in the local area. In such cases, coordination is largely an intra-agency function. In other areas, the answer as to where the coordinating function will be located is not as clear.

RECOMMENDATION 10: To be effectively delivered, the various components of community support services must be coordinated at the client's level. This client level coordination must set priorities for the expenditure of resources and must also insure needed services are developed. The Department of Mental Health and Mental Retardation in consultation with the Maine Commission on Mental Health, mental health professionals, consumers, and family members shall make recommendations to the Legislature on a mechanism for coordinating services by January 1990.

Case Management

Even where there are inter-agency linkages at the local level, individuals seeking help are often left to coordinate services they need from serveral different providers. Case managers would provide a coordination link at the individual

level. The case managers can also be an important element in the community services package. They can provide training in activities of daily living around household tasks and help individuals with mental illness seek out and coordinate the services they need. Family, friends and volunteers have traditionally filled the role in the past. Case managers can provide a formal backup, respite or replacement for that informal support structure. The traditional (non-therapeutic) social welfare worker or visiting nurse service provides a professional source for some of this support system. The special needs of psychiatric patients and the limited resources available from these other sources argues for the development of a special case management service.

The preceding description of case managers assumes that they also play a service-providing role. They would be a support to the individual and be a source of training in activities of daily living. Another model for case managers is that of "broker." Here the case manager is less a provider of service than a coordinator of services provided by various other independent agencies. In the discussions of the Commission, the "case manager as service provider" model almost assumes that the manager service is part of a larger multi-purpose, core community support agency. The "broker" model implies a number of separate agencies each of which provides a needed service but which, at best, have ad hoc cooperation agreements. One of these agencies may be providing the home based activities of daily living support, but the client is likely to find the total array of services confusing and disjointed. The Commission did not agree that one model was preferable for all parts of the state.

Through the Commission's discussions it was also apparent that the two models required different levels of staffing. In the "case manager as service provider" model, the manager to client ratio would average 1 to 10. If the activity of daily living support and training service were provided elsewhere, the "broker" model could function with average case loads of 30 to 40.

In close coordination with crisis management services, either case management model could act as a gatekeeper to screen admissions to the State mental health institutes.

RECOMMENDATION 11: Case management services should be part of the package of client support services available in all areas of the state. A case manager should be responsible for insuring that mentally ill individuals receive the services they need and that their rights are protected. The Department of Mental Health and Mental Retardation in consultation with the Maine Commission on Mental Health, mental health professionals, consumers and family members shall develop a model of case management services by January 1990.

Crisis Stabilization

In addition to needing general help in management of their situation, a person with mental illness may experience an acute episode which may require intensive intervention by someone with special skills. Case managers may be able to provide some of this crisis intervention support themselves. In other cases they need to have access to special crisis stabilization services. Crisis stabilization would provide support to individuals in their own home or other community residence, which would help the individuals get through the acute episode without hospitalization.

Together, case managers and crisis support services could also act as gatekeeper to limit hospitalizations in either local community hospital units or the State institutes.

The pilot projects for "case management" services and crisis intervention services tried in the past year in several locations in the state have provided useful information as to how these should be structured. As would be expected, one of the elements for success was that the service be available on a 24 hour, 7 day a week basis. The Legislature, in its fall special session, decided that the crisis intervention workers should remain State workers and added six new positions. Discussions as to what is the most appropriate model for the provision of crisis intervention services will continue in the next budget period.

RECOMMENDATION 12: Crisis stabilization services should be a part of the total package of services available to chronically mentally ill individuals in all areas of the state and shall work in concert with case management services. Upon release from the hospital, there should be a continuity of medical and psycho-therapeutic services to insure every opportunity for the individual to remain in the community.

IV. INPATIENT SERVICES IN LOCAL HOSPITALS AND NURSING HOMES

There are two cases where mentally ill individuals might need an institutional setting for care other than one of the two mental health institutes. One would be for a short term or acute hospitalization. The other is more long term care in a nursing home. These services typically have been provided at the mental health institutes, but they can also be provided in more local settings.

Hospital Inpatient Services

The image presented to the Commission was of a person experiencing an acute episode of mental illness being taken by local ambulance or police on a several hour long ride past numerous, under utilized local hospitals. The person is eventually admitted to AMHI or BMHI only to find that the acute episode is largely over on arrival. The ill person does not receive the care needed in a timely fashion. The State's resources are not utilized in an effective manner.

If inpatient services had been available in the individual's local community, the individual may have been willing to be voluntarily admitted and hence avoid the involuntary admission at one of the State mental health institutes. Even if the individual had been initially unwilling to be admitted as a voluntarily patient, if the local hospital had been able to admit the individual as an involuntary patient for one or two days, the individual might, once the acute phase was over, have been willing to agree to be admitted voluntarily.

As presented to the Commission, the situation appears to arise from a number of interrelated factors. First, there is the issue of involuntary admissions. Even if inpatient services are available in a local hospital, the patient may not be willing to be admitted voluntarily. Second, there is a problem of coordination with other local services. The inpatient service may fill a particular need with the community. The local hospital may not be willing, or have the capacity, to coordinate or cooperate with other local service providers to meet the needs of all acutely ill persons. Third, the certificate of need process may act as a hindrance to those hospitals which want to establish psychiatric units. In addition, the overall limit on certificate of need approvals in a given year would restrict the development of low priority services. Fourth, a particular hospital, even if they have an excess capacity, may not see mental health services as within the mission of their hospital or may not wish to serve individuals with mental illnesses because they are concerned about the reactions of other patients. Finally, a particular hospital may be willing to establish an inpatient service but find there is a shortage of qualified professionals in their area to staff a psychiatric unit.

Involuntary Admissions

This issue was largely posed in terms of liability for the psychiatrist admitting the patient and the hospital with the unit. Voluntary admissions are free to leave the hospital when ever they want, similar to any other patient in the hospital. If they harm themselves or others, the hospital or the treating psychiatrist is not necessarily liable. With an involuntary admission, the hospital has added responsibility for protecting the rights of the involuntary patient and liability for protecting other patients or the general public.

The solutions suggested to the problem focussed on providing some immunity to the hospital or practicing professional. In particular, the discussion mentioned a special grant of immunity to certain institutions for particular types of patients. Another alternative was making the psychiatrist at the local unit a State employee, at least for the purposes of admitting involuntary patients.

How serious a problem this actually poses for hospitals and psychiatrists was not entirely clear. Jackson Brook Institute in Portland, even though it is a private hospital, does take involuntary admissions under certain circumstances. In addition, the Community General Hospital in Fort Fairfield in the Aroostook county region is planning to accept involuntary admissions into its inpatient unit. Their plan is to take those patients whose symptoms are expected to clear within the 5 day emergency commitment period. They have worked with the Attorney General's Office and BMHI to make the process work effectively and to protect the rights of patients. Once the acute symptoms clear, the expectation is that the patient would agree to a voluntary commitment if they needed additional inpatient treatment. The hospital does not at present plan to take more serious cases or individuals whose illness are expected to be of a longer duration.

RECOMMENDATION 13: The Department of Mental Health and Mental Retardation should work with the Attorney General's Office to expedite the development of procedures for the treatment of involuntary patients in local hospital psychiatric inpatient units. This should include a mechanism for timely transfers to one of the two State mental health institutes and for the protection of individual patient's rights.

Coordination

The issue of coordination was specifically raised concerning only one hospital. The hospital was perceived in the community as acting as though it was an entity unto itself. On the other side, community based inpatient units in this and other hospitals were described as usually at capacity. They often have waiting lists. The Commission did not examine in detail to what degree the lack of cooperation is

due to an unwillingness to adapt to community needs or to a limited capacity to accommodate additional demands for service. Coordination, however, was considered a general problem in the organization of community services and was seen as involving the inter-relationship among these other community services as well as the relationship between these services and hospital inpatient units.

If the capacity in hospitals presently operating inpatient psychiatric units is insufficient and unable to be expanded, there may be other hospitals in the region which would be able to serve the needs of community agencies. Where the capacity is limited, the Department of Mental Health and Mental Retardation should consider ways to encourage other hospitals in a region to develop inpatient services which would fill the need of other community agencies and crisis stabilization services for cooperative arrangements with an inpatient facility. Where possible, these new inpatient services should include a capacity to take involuntary patients.

RECOMMENDATION 14: The Department of Mental Health and Mental Retardation, the Department of Human Services, and the Maine Health Care Finance Commission (MHCFC) should set up a working group to develop appropriate regulations or proposed statutory changes so that State funding and approval mechanisms require hospital inpatient units and community service providers to communicate and cooperate on the treatment and transfer of patients between inpatient and community service programs.

Certificate of need

The certificate of need process (CON) was mentioned as a possible hindrance to the development of services. In the discussions, it became clear that this was true if the intent was to expedite the development of services. In the normal process, however, it did not appear that the certificate of need process itself was a major hindrance to the development of services. If DMH&MR had a statewide plan for services and a hospital's plan was in response to a request for proposals from the State, the certificate of need hurdles would be automatically reduced.

The final decision of whether a project is approved for development in a given year depends on the nature of other proposals competing for limited funding and on the overall limit on funding approvals in a given year. If the development of inpatient psychiatric services is considered a priority, the Legislature could specify the priority ranking of CON approvals or they could provide additional funding for those psychiatric units which otherwise meet CON approval standards.

RECOMMENDATION 15: The Department of Mental Health and Mental Retardation should conduct a statewide assessment of the need for psychiatric inpatient units in local community hospitals. This assessment should be incorporated in the system's study. Based on this assessment they should develop a plan for the location of community hospital inpatient units across the state. They should work with the certificate of need process in the Department of Human Services to provide the information which would expedite the applications of hospitals which meet the goals of the statewide plan.

Mission of The Hospital

The goal behind encouraging local community hospitals to have inpatient psychiatric units is to insure these services are available in all areas of the state. These community hospital inpatient units, therefore, should serve a given geographic area and be distributed across the state. The area of coverage should include a sufficient population base to insure the operation of an effective and efficient unit. If a systematic statewide plan was carried out, it would suggest certain locations over others. On the other hand, hospitals are independent agencies. The State could solicit requests for proposals, possibly restricted to specific geographic service areas, but not require a hospital to develop the service. Hospitals would only submit proposals if they saw the services to be within the scope of their larger mission. The question is how much the State should try to encourage specific hospitals which fit into a statewide service plan to develop inpatient services and how much they should rely on local hospital boards to define it as part of their mission.

The Commission asked how many hospitals might be interested in developing inpatient psychiatric services and requested the Hospital Association to poll its members. The Hospital Association raised the issue of the lack of clear guidelines as to the type of services and the regulations that would be promulgated for providers. They felt that hospitals would need to know what the requirements for space and staffing would be before they could examine whether it was feasible or desirable for them to develop such services. A request was made of DHM&MR to develop guidelines. DMH&MR agreed it needed to be done. However, this task basically entails developing the standards to be used in any future request for proposal initiative the department might develop, and the department did not expect this task would be completed within the time frame of the Commission's work.

RECOMMENDATION 16: The Department of Mental Health and Mental Retardation should actively bring community mental health providers and providers of hospital services in an area together and have them discuss how inpatient services should be developed in their area. The aim should be to provide necessary in-patient services based on client need within the

local community. The Department should assist in the development of inpatient psychiatric units in those geographic areas where the department's assessment has determined that there is a need for a unit. The Department should report annually to the Maine Commission on Mental Health on its progress in implementing a plan for in-patient services. It is the intent of the Commission that all psychiatric beds in Maine shall adhere to patient rights and advocacy rules.

Shortage of Qualified Professionals

In testimony before the commission, the hospital administrator at the Calais Regional Hospital described their efforts to develop an inpatient psychiatric service. The hospital's board of trustees was behind the development and the CON process was manageable. At the time of the hearing, however, the service appeared unlikely to be established because the hospital could not find qualified staff in the area. This included staff at both the psychiatrist and psychaitric nursing levels. The question was raised whether the recruitment of staff, or the development of locally based continuing education programs, to insure the availability of needed professionals should be totally the responsibility of each local hospital or partly a responsibility of central State agencies or public and private educational institutions.

RECOMMENDATION 17: The Department of Mental Health and Mental Retardation should assess the need and availability of mental health professionals and workers in all regions of the state. They should develop a plan with the Department of Education, the Vocational-Technical Institute System, the University of Maine System, and other private, post secondary educational institutions to provide the preservice and continuing education programs necessary to provide the personnel resources to meet the need in all regions of the state.

Payment and Reimbursement Policies

Under the present payment structure, mental health services are paid for out of State or private sector funds. The issue of who pays for services comes down to three choices. One possibility is state payment. The State has been responsible for inpatient treatment at the State's two mental health institutes. If inpatient services are to be developed in the community, patients who represent a reduction in admissions to the mental health institutes should be paid for by direct grant from the State. A second possibility is that local hospital services would be covered by private payor and third party payors. This is presently how the system operates for private and community hospitals. It does not cover those individuals who do not have the personal resources, whose health insurance coverage has run out or who do not have insurance. A third alternative is to include inpatient psychiatric services in the State's method of dealing with bad debts in hospitals under the Maine Health Care Finance Commission.

The problem with the first approach is that while it would insure the development of local services and provide the clearest mechanism for systematic planning of where the services would be developed, it would require increased appropriations by the State. The second approach only meets the needs of that portion of the population with resources. There is a substantial segment of the population who do not have health insurance coverage, especially for psychiatric services. The final approach, including the costs under MHCFC, has a certain appeal. However, there is a growing concern about the general increase in the cost of health insurance to employers and individuals. Treating psychiatric services within the bad debt mechanism of the Maine Health Care Finance Commission would have the general effect of increasing insurance costs.

A larger issue in the whole payment structure, however, is whether there should be a greater federal role in the payment for the care and treatment of persons with mental illness. Through Medicare and Medicaid, federal government does play a significant role in the payment of medical treatment for other types of illnesses. These programs will also pay for the care and treatment of the somatic illness and disabilities of individuals who are mentally ill. Medicare and Medicaid, however, are becoming increasingly restrictive when mental illness is the primary condition requiring hospitalization or nursing home services.

RECOMMENDATION 18: The Governor should inform both the President of the United States and the Maine Congressional delegation that it is imperative that the Federal government should participate to a greater extent in the funding of mental health services. Mental illnesses should be treated like other illnesses and disabilities. Federal programs like Medicare and Medicaid should pay for the care and treatment of the mental illnesses of otherwise eligible individuals. The Governor should direct the State Medicaid Agency to review mental health services in order to guarantee the maximization of Medicaid funds for needed client services.

New federal regulations under PL99-66 require states to develop a plan for reducing the use of inpatient services. This planning process will provide an opportunity to address the statewide availability of inpatient treatment opportunities.

Nursing Home Services

Mentally ill individuals may also have medical problems which require a level of nursing care that can only be provided in a nursing home setting. Whether community nursing homes are appropriate facilities for the care and treatment of certain mentally ill individuals rests on four factors. First, does the client's physical disability require a nursing home level of service. Second, can the needed psychiatric support

services be provided in the nursing home to deal with the mental illness, as well as the somatic problems, of the patient. Third, is there capacity in the present nursing home system. Fourth, what are the federal regulations regarding the placement of individuals who have mental illness in nursing homes.

Treatment and Support Services

The existing staffs of nursing homes are generally not trained to deal with patients with mental illness and there is a concern, addressed in recent federal legislation, that mentally ill individuals who have been placed in nursing homes are not receiving the appropriate active treatment. If nursing homes were to be one of the community options for the care and treatment of individuals who have a mental illness, in addition to their somatic problem requiring nursing home level of care, then existing staff would have to be provided additional training, and certain specialty services would have to be added to those already available in the home. This would entail developing a mechanism for administering the educational programs. It would also require additional funding to pay for the educational programs, salary upgrades to compensate for the additional skills required of staff, and funding to pay for the added psychiatric treatment services.

Capacity

The capacity question has two parts. First, existing nursing homes may not be able to care appropriately for patients with mental illness without added renovations to their physical plant. The structural safeguards or facilities needed may vary with the types of patients served, but some general guidelines could be developed. The second issue concerns the general capacity of nursing homes to meet the demand for service. Unlike general hospitals, there does not appear to be an excess capacity in nursing homes. With the present number of nursing home beds, there may not be places to add a new client group. On the other hand, nursing homes may already be serving a number of patients who have a mental illness in addition to their somatic problem. The question then would be not whether but which mentally ill individuals should be served in nursing homes.

Federal Regulations

The new federal requirements for nursing homes are designed to improve the care of individuals in nursing homes. They set standards for the quality of life and service provided by the home. They address the patients' rights to good treatment and confidentiality. They provide standards for training of personnel.

The area of particular concern to the Commission relates to the requirements regarding preadmission screening and resident reviews to determine whether they have a mental illness. These sections:

1. Define a person as mentally ill "if the individual has a primary or secondary diagnosis of mental disorder . . . and does not have a primary diagnosis of dementia."

2. Require the State to "have in effect a preadmission screening program, for making determinations . . . for mentally ill and mentally retarded individuals . . . who are admitted to nursing facilities on or after January 1, 1989

3. "As of April 1, 1990, in the case of each resident of a nursing home facility who is mentally ill, the State mental health authority must review and determine . . .

> "(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 . . . or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and
>
> "(II) whether or not the resident requires active treatment for mental illness"

4. The requirements differentiate among three categories of residents <u>who do not require the level of service provided by the nursing home</u>. Those who:
- o Require active treatment from mental illness but have resided in a nursing facility for at least 30 months before the date of the determination under these requirements.
- o Require active treatment from mental illness but have resided in a nursing facility for less than 30 months before the date of the determination under these requirements.
- o Do not require active treatment for mental illness.

In the first case the State must inform the patient of other treatment options but not require them to leave the home. In the latter two cases, the State must arrange for a "safe and orderly discharge of the resident from the facility." If the resident is mentally ill, the State must arrange for active treatment for the mental illness.

The general intent of the requirements is to insure that nursing home residents receive appropriate care. Part of what is considered appropriate care is to provide active treatment

for individuals with mental illness. The troubling part for the Commission is that there is an implied assumption in the legislation that nursing homes are not an appropriate place for providing active treatment for mental illness. If this assumption is based on the general societal prejudice that mentally ill should be segregated from the rest of society, then the federal legislation is flawed. If it is based on the fact that active treatment would cost more than the allowable costs under Medicaid, then Medicaid reimbursement policies need to be addressed. An appropriate basis for the assumption may be, however, that in balancing the needs of the mentally ill individual with other nursing home residents the presence of a mentally ill patient is too disruptive for the proper care of other patients.

The whole concern with this legislation may also be somewhat exaggerated. Nursing homes only need to find alternative placement if a resident of the home does "not require the level of services provided by a nursing home facility." This means the level of care for a somatic illness. The only individuals who have to be moved are those mentally ill individuals who do not also have a medical problem which needs the level of medical care offered by a nursing home. Other patients with mental illness can be cared for in nursing homes as long as appropriate active treatment for each patient's mental illness is provided.

Active treatment for mental illness could either be provided by the nursing home or under a cooperative agreement with other community agencies. In the latter case, direct care staff would still need to be trained to provide nursing care for mentally ill individuals. The cooperative agreement would also have to meet federal regulations as to what constitutes appropriate active treatment.

RECOMMENDATION 19: The Department of Mental Health and Mental Retardation should develop a plan for delivering active treatment for persons with mental illness in nursing homes. Local mental health providers should be consulted in developing the plan.

Federal Reimbursement

The federal rules governing the payment of mental health services differ depending upon whether the payment source is Medicare or Medicaid, the age of the patient, and whether the location of treatment is in a State facility. Medicaid will pay for the care and treatment of an individual with an acute mental illness if the individual is treated in a private or non-profit hospital. If an individual is in a skilled nursing home, or other long-term care facility (e.g. an ICF), Medicaid will only pay for the active treatment of an individual's mental illness. It will not pay for the care of the individual unless the reason the individual is in a nursing home is because of a somatic problem

requiring nursing home level of care. If more than 50% of the individuals in a nursing home are under the age of 65 and are at the nursing home because of their mental illness, federal rules reclassify the home as an institution for mental disease (an IMD). In this case, Medicaid will neither reimburse the institution for the active treatment of the mental illness nor room and board care for any of the individuals in the institution.

Medicare will pay for the treatment and care in skilled nursing homes of those over age 65, or who are classified as disabled and eligible for Medicare under Social Security. They will also pay for the care and treatment of individuals in State facilities.

V. OVERCROWDING AND STAFFING ISSUES AT AMHI AND BMHI

While the major focus of the second Commission report is on community based services, two new issues directly affecting AMHI and BMHI were examined by the Commission. One concerned Medicare reimbursement of services provided at AMHI. The other concerned the closing of a ward at the Togus Veterans Hospital.

Medicare Certification of AMHI

The Medicare issue arose when the federal review of AMHI found the institute to be out of compliance in certain areas. Medicare appears to have been strengthening or adjusting their standards from year to year. AMHI over the past number of years has skirted the border of being in compliance or provisionally in compliance with Medicare regulations. In the latest review, the line was drawn placing AMHI in noncompliance. This necessitated action by DMH&MR to address the areas of concern to the federal government. These largely entailed the addition of certain types of staff. Another review committee was established by the Legislature comprised of the chairs of this Commission plus the chairs of the Joint Standing Committees on Human Resources and Appropriations and Financial Affairs to review the budgets at AMHI and BMHI.

Togus Veterans Hospital

Togus Veterans Hospital had a problem similar to AMHI's in meeting standards for staffing. A shortage of psychiatric staff created the need to close one ward in order to remain in compliance with staff to patient ratios. The hospital is attempting to recruit an additional psychiatrist. In the interim, some patients who would have otherwise sought treatment at Togus have applied for admission to AMHI.

The irony of the situation did not escape the Commission's notice. While one federal agency solves its problems by reducing its service and thereby increasing the patient load at AMHI, another federal agency was withdrawing federal reimbursement for AMHI because the patient to staff ratios were too high. Since AMHI must serve all individuals needing involuntary placement, the institute had no choice but to accept the additional patients.

The common problem faced by both Togus and the State institutes is the shortage of certain categories of professional staff. If they both carry out independent recruitment efforts, they run the risk of attracting each other's staff rather than adding to the total pool of professionals in the state. This is an issue not only between Togus and the institutes but also includes community providers and those in private practice. The Commission members were interested in the parties exploring whether a common recruitment effort could be initiated in an effort to insure

that the end result is an increase in the total number of mental health professionals in the state.

RECOMMENDATION 20: The Department of Mental Health and Mental Retardation should work with the Veterans Hospital at Togus, community mental health providers, private institutions, and professional groups to develop a joint recruitment effort to attract needed mental health professionals to Maine.

VI. CONCLUSIONS

The Second Special Session of the 113th Legislature made some initial steps toward developing an adequate system of community services. Some of the staffing and program shortfalls at the two State mental health institutes were initially addressed. They increased funding for community services including expanded crisis intervention and case management services. Finally, they established, in statute, the Maine Commission on Mental Health to provide oversight for the mental health institutes and act as an advisory body to both the executive and legislative branches.

The Commission on Overcrowding hopes that the Maine Commission on Mental Health will find the material presented in this report instructive in their future deliberations and that it will serve as a beginning work plan.

APPENDIX A

FIRST REGULAR SESSION

ONE HUNDRED AND FOURTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY NINE

AN ACT to Restrict State Grants for Community Mental Health Services to Agencies which Provide Salaries Comprable to Equivalent State Positions.

Be it enacted by the People of the State of Maine as follows:

34-B MSRS §3604 is amended as follows.

§3604 Commisioner's Powers

1. Provision of services. The commissioner may provide mental health services throughout the State and for that purpose may cooperate with other state agencies, municipalities, persons, unincorporated associations and nonstock corporations.

2. Funding sources. The commissioner may receive and use for the purpose of this subchapter money appropriated by the State, grants by the Federal Government, gifts from individuals and gifts from any other sources.

3. Grants. The commissioner may make grants of funds to any state or local governmental unit, or branch of a governmental unit, or to a person, unincorporated association or nonstock corporation, which applies for the funds, to be used in the conduct of its mental health services.

A. The programs administered by the person or entity shall provide for adequate standards of professional services in accordance with state statutes.

B. The commissioner may require the person or entity applying for funds to produce evidence that appropriate local, governmental and other funding sources have been sought to assist in the financing of its mental health services.

C. After negotiation with the person or entity applying for funds, the commissioner may execute a contract or agreement for the provision of mental health services which reflects the commitment by the person or entity of local, governmental and other funds to assist in the financing of its mental health services.

D. Beyond the commissioner's assuring through program monitoring and auditing activities that an equitable distribution of the funds committed by contract or agreement to assist in the financing of mental health services are actually provided, it shall be the prerogative of the person or entity providing services to apportion other nonstate funds in an appropriate manner in accordance with its priorities, service contracts and applicable provisions of law.

E. Any contract or agreement for the provision of services must insure that the staff having direct contact with individuals receiving mental health servces are paid on salary scales comprable to those of state employees who provide similar services.

STATEMENT OF RACT

The bill would require community mental health agencies providing services under State contracts to pay salaries comprable to those provided state workers who perform similar duties.